FOP ENHANCED PLAN: Louisville Metro Government

Coverage Period: 07/01/2014 – 06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by contacting mybenefits@louisvilleky.gov or by calling 1-502-574-8100.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In-network providers **N/A** single/**N/A** family per plan year. For Out-of--network provider's **$50** single/**$150** family. **Coinsurance** & **copayments** don't apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes.** For In-network providers **$400** single/**$1,200** family per plan year. For Out-of-network provider's **$400** single/**$1,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover..	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.humana.com** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and

the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

- This plan may encourage you to use In-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a In-network Provider	Your Cost If You Use a Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 **copayment**/visit	20% after **deductible**	——————none——————
	Specialist visit	$20 **copayment**/visit	20% after **deductible**	——————none——————
	Other practitioner office visit (chiro)	$10 **copayment**/visit	20% after **deductible**	Limited to 12 visits per year.
	Preventive care/screening/immunization	No charge	20% after **deductible**	Mammograms limited to 1 per year.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% after **deductible**	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	20% after **deductible**	Out-of-network inpatient/outpatient Not covered.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com.	Level 1 - Lowest cost generic and brand-name drugs Retail Mail order	 $3 $6	Not covered	-Retail day supply 30. -Mail day supply 90. -Flu and Pneumonia immunizations and drugs on the Women's Healthcare drug List at In-network pharmacies: No charge. -Prior auth and step therapy may be required for some medications. -Pharmacy **Out-of Pocket** limit for PAR providers $400 single/$1,200 family; Non PAR
	Level 2 - Higher cost generic and brand-name drugs Retail Mail order	 $7 $14	Not covered	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2 Retail Mail order	 $15 $30	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use a In-network Provider	Your Cost If You Use a Out-of-network Provider	Limitations & Exceptions
	Specialty drugs if: -Obtained at the pharmacy -Paid under medical benefits -Obtained through SpecialtyRX and office administered by provider	-Same as Level 1, 2 or 3 -Medical benefits apply -No Charge	-Same as Level 1, 2 or 3 -Medical benefits apply -Not applicable	providers: Not applicable. The limit applies to all levels and is integrated with medical plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	————————none————————
	Physician/surgeon fees	No charge	Not covered	————————none————————
If you need immediate medical attention	Emergency room services	$75 **copayment**/visit	$75 **copayment**/visit	Non-emergency Not covered.
	Emergency medical transportation	No charge	No charge	————————none————————
	Urgent care	$50 **copayment**/visit	20% after **deductible**	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Prior auth is required. Failure to do so will cause **coinsurance** to reduce to 50%
	Physician/surgeon fee	No charge	Not covered	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 **copayment**/visit	20% after **deductible**	————————none————————
	Mental/Behavioral health inpatient services	No charge	Not covered	Prior auth is required. Failure to do so will cause **coinsurance** to reduce to 50%
	Substance use disorder outpatient services	$10 **copayment**/visit	20% after **deductible**	————————none————————
	Substance use disorder inpatient services	No charge	Not covered	Prior auth is required. Failure to do so will cause **coinsurance** to reduce to 50%
If you are pregnant	Prenatal and postnatal care	$20 copayment	Not covered	Office visit **copayment** applies to the initial visit only.
	Delivery and all inpatient services	No charge	Not covered	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a In-network Provider	Your Cost If You Use a Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% after **deductible**	Limited to 30 visits for Out-of-network benefits.
	Rehabilitation services	$10 **copayment**/visit	20% after **deductible**	-Chemotherapy, radiation and cardiac rehab In-network inpatient 80%, In-network outpatient No charge. Out-of--network Not covered. -Limited to 20 combined visits for Physical, Occupational, Speech, Cognitive, and Acupuncture Therapies.
	Habilitation services	$10 **copayment**/visit	20% after **deductible**	
	Skilled nursing care	No charge	Not covered	-Limited to 60 days. -Prior auth is required. Failure to do so will cause **coinsurance** to reduce to 50%.
	Durable medical equipment	20%	Not covered	-Wigs: Not Covered -Prior auth may be required. Failure to do so will cause **coinsurance** to reduce to 50%
	Hospice service	No charge	No charge	Prior auth is required. Failure to do so will cause **coinsurance** to reduce to 50%.
If your child needs dental or eye care	Eye exam/Refraction	No charge	20% after **deductible**	Out-of-network refraction benefit Not covered
	Glasses	Not covered	Not covered	No coverage for glasses.
	Dental check-up	Not covered	Not covered	No coverage for dental check-ups.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Dental care (adult and child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (inpatient only)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care (Limited to 12 visits)
- Cosmetic surgery (Requires prior auth. Services will only be considered if due to a bodily injury or illness and functional impairment is present.)
- Hearing aids (limited to $1,400 per hearing impaired ear once every 3 years for children to age 19 only)
- Routine eye care (Adult and child) Exam and refraction only

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-502-574-8100. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,360
- **Patient pays** $180

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$30
Coinsurance	$0
Limits or exclusions	$150
Total	**$180**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$250
Coinsurance	$150
Limits or exclusions	$80
Total	**$480**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-502-574-8100 or visit us at mybenefits@louisvilleky.gov
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov to request a copy.